

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

241 N. Charles St., Baltimore

552

10445

CERTIFICATE OF DEATH

Reg. Dist. No. 933

1. PLACE OF DEATH

County McComieCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
P.O. #1

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County McComieCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. P.O. #1
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

George Edwin Adkins

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

Mary Jane Adkins

7. Birth date of

deceased (mo., day, yr.)

Sept. 28 - 1871

6. (c) If alive, give age

Dead years

8. AGE:

Years

Months

Days

If less than one day

74 1 17 hrs. min.

9. Birthplace

McComie Co. Maryland
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Farmer

FATHER

12. Name

James Benjamin Adkins

MOTHER

13. Birthplace

McComie Co. Md.

14. Maiden name

Olivia Hillman

15. Birthplace

McComie Co. Maryland

16. Informant

Mr. Elton J. Adkins

Address

P.O. #1, Salisbury Md.

17. Burial

(Burial, cremation, or removal, which?)

Buried

Date thereof

Nov. 19 - 1947

Cemetery or crematory

Prison Cemetery

Location

Salisbury Maryland

18. Funeral Director

William C. Martin R. Hillman

Address

Salisbury Maryland

19. Date rec'd by registrar

11/19/47

20. Date of death

Nov. 15

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 15 1947 at 9:15 a.m.

and that I last saw h

Nov. 15 1947 alive on Nov. 15 1947

Immediate cause of death

Arteriosclerosis - Card. Vasc. Next Den.

Due to

Diabetes Mellitus

Due to

Cere. p. nec.

Other conditions

Cere. p. nec.

(Include pregnancy within 3 months of death)

Cere. p. nec.

Major findings of operations

Cere. p. nec.

Autopsy results

Cere. p. nec.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

Cere. p. nec.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 15

19

47 at 9:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 15 1947 to Nov. 15 1947and that I last saw h Nov. 15 1947 alive on Nov. 15 1947

Immediate cause of death

Arteriosclerosis - Card. Vasc. Next Den.

Due to

Diabetes Mellitus

Due to

Cere. p. nec.

Other conditions

Cere. p. nec.

(Include pregnancy within 3 months of death)

Cere. p. nec.

Major findings of operations

Cere. p. nec.

Autopsy results

Cere. p. nec.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

Cere. p. nec.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Lu L. Lundy M.D.

M. D. or other

Address

Date signed

11/19/47

Registrar

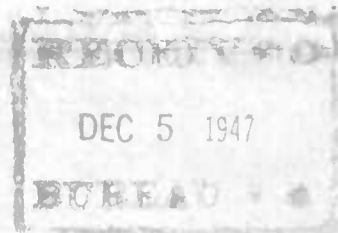
Date signed

Scotts

~~Robert Gifford~~
~~Embassy~~ ~~Yut.~~

~~with anti 1302~~

Levin unap



D. Rademaker

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1702

10446

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 12 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 108 West Grabella Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Austin, Alan

(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

8.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 15th 1943
6.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

4322

_____hrs.

_____min.

9. Birthplace

Augusta Maine
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Kenneth Percy Austin

13. Birthplace

South China Maine

MOTHER

14. Maiden name

Arleta Brown

15. Birthplace

Randolph County N.C.

16. Informant

M. Kenneth P. Austin

Address

108 N. Grabella St. Salisbury Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Nov. 10 - 1947
(month) (day) (year)

Cemetery or crematorium

McMills Mem. Park

Location

Salisbury Maryland

18. Funeral director

Walter R. Holliday

Address

Salisbury Maryland

19.

11/10/47
(Date rec'd by registrar)

19

4711-8-47RegistrarRegistrar

23. SIGNATURE

Dr. Rademaker M.D.

M. D. or other

Address

Salisbury MdDate signed 11-8-47

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7th 1947 at 11:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____ and that I last saw him _____ 19____

Immediate cause of death fractured skullBrain injury

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. _____

Autopsy requested no

PHYSICIAN Please underline the cause to which death should be charged statistically.

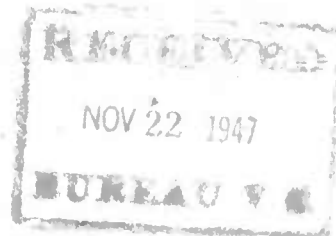
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 11-7-47Where did injury occur? Salisbury Wicomico Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) city streetInjury Ran into truck Injured at work? noSignature Dr. Rademaker M.D.Address Salisbury Md Date signed 11-8-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

10447

Reg. Dist. No. 93.3

1. PLACE OF DEATH:

County Wicomico
City or town Pittsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED;

(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Pittsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war no

3. (a) FULL NAME

Annie D. Baker

3. (b) Social Security Number

none

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female white Widowed

6.(b) Name of husband or wife R. J. Baker

7. Birth date of deceased (mo., day, yr.) Feb. 22 - 1868 6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day

89 8 19 hrs. min.

9. Birthplace New Hope, Wicomico, Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name Edward Williams

13. Birthplace Maryland

14. Maiden name Lama A. Hardy

15. Birthplace Maryland

16. Informant C. Lee Baker

Address 308 E. Pine St. Salisbury, Md

17. Burial Date thereof Nov 13/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Grace Methodist

Location Pittsville, Md

18. Funeral director Way E. Dennis

Address Snow Hill, Md

19. 11/13 19 47 W. A. Barrish Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11 19 47 at 5:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1945 19 to day of death 19 day 7 death and that I last saw him alive on 19

Immediate cause of death myocarditis, chronic DURATION 2 yrs.

Due to

Due to

Other conditions chronic nephritis

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank R. Long M. D. or other

Address Hallards Md Date signed 11-11-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

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DEC 5 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 10448
 Reg. Dist. No. 333

1. PLACE OF DEATH:

County Thomson
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 days - 15 hrs - 20 min
 Hospital, institution, or street address where death occurred:
Penninsula General Hospital
 How long in hospital or institution? 3 days - 15 hrs - 20 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Delaware County Sussex
 City or town Laurel
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war. _____

3. (a) FULL NAME

Baker, Mr Frank

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Jennie Baker 6.(c) If alive, give age 31 years
 7. Birth date of deceased (mo., day, yr.) Dec 2 1877
 8. AGE: Years 69 Months 11 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace Delaware
 (Town, county, and state)
 10. Usual occupation Carpenter
 11. Industry or business _____
 12. Name Lewis T Baker
 13. Birthplace Delaware
 14. Maiden name Jennie Stanley
 15. Birthplace Delaware

16. Informant Jennie Baker
 Address Laurel Del
 17. Burial (Burial, cremation, or removal? Which?) Date thereof Nov 26 47
 (month) (day) (year)
 Cemetery or crematory Laurel Hill Cemetery
 Location Laurel Del
 18. Funeral director J. J. Dineen
 Address Laurel Del

19. 11/26/47 (Date read by registrar) Registrar W. H. Harrison

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 1947 at 8:50 PM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/16 to 11/24 and that I last saw him alive on 11/24

Immediate cause of death Bilateral Bronchopneumony
due to Congestive Heart Failure
which edema (pulmonary)
due to Nephrosclerosis with
uremia
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Charles M. Moyer M. D. or other _____
 Address Laurel Del Date signed 11/24/47

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10449

Reg. Dist. No. 303

1. PLACE OF DEATH:

County Wicomico Co.
 City or town Salisbury Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? app. 12 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico Co.
 City or town Salisbury Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 108 Jenkins St. Salis.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Barkley

3. (b) Social Security Number

4. Sex Female 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife
 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 55 Months 0 Days 0 If less than one day
 hrs. min.

9. Birthplace Allen Md.
(Town, county, and state)10. Usual occupation Domestic

11. Industry or business

12. Name un known

13. Birthplace

14. Maiden name un known

15. Birthplace

16. Informant Latie New KirkAddress 108 Jenkins St17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Nov. 26 1947
(month) (day) (year)Cemetery or crematory Allen CemeteryLocation Allen Md.18. Funeral director Brooks M. LeestAddress 715 Lake St. Salisbury19. 11/26/47 47 Harriet L. Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23rd 1947 at 2:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 16 1947 to Nov. 23 1947
 and that I last saw him/her alive on Nov. 16 1947

Immediate cause of death

Cerebral Pneumonia

DURATION

Due to Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William D. Gray, MD M. D. or otherAddress Salisbury, Md. Date signed 11/25/47

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DEC 8 1947

BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

10450

CERTIFICATE OF DEATH

Reg. Dist. No. 9.33

1. PLACE OF DEATH:

County... Harmon

City or town... Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution? 3 days 9 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland

County... Lancaster

City or town... Snow Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Beuman, Baby Boy Charles Lee

3. (b) Social Security Number

4. Sex

Male

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Just born

6. (b) Name of husband or wife

mother Mrs Irene Beuman

7. Birth date of

deceased (mo., day, yr.)

11/4/47

6. (c) If alive, give age..... years

1 day

8. AGE:

Years

Months

Days

If less than one day

3

9 hrs.

min.

9. Birthplace

Salisbury, Harmon Co, Md.

(Town, county, and state)

10. Usual occupation

Newborn

11. Industry or business

FATHER

12. Name

Beuman, Robert

13. Birthplace

Grindstone, Md.

MOTHER

14. Maiden name

Burns, Irene

15. Birthplace

near Snow Hill, Md.

16. Informant

Mrs Irene Beuman

Address

17.

Cremation
(Burial, cremation, or removal. Which?)

Date thereof

11/8/47
(month) (day) (year)

Cemetery or crematory

Peninsula General Hospital

Location

Salisbury, Md.

18. Funeral director

Peninsula General Hospital

Address

Salisbury, Md.

19.

11/10/47
(Date filed by registrar)

19.

Barrett, John
Registrar

23. SIGNATURE

Robert L. La Mar, MD
Address Snow Hill

M. D. or other

Address

Date signed 11-7-47

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 7

19 47, at 4:45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 4

19 47

to Nov. 7

19 47

and that I last saw him alive on

Nov. 7

19 47

Immediate cause of death

Circulatory + Respiratory
insufficiency

DURATION

4 H.

Due to

Prematurity (2 lbs. at Birth)

3 days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

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NOV 22 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10451

CERTIFICATE OF DEATH

Reg. Dist. No. 383

1. PLACE OF DEATH:

County NicomisCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long above place of death?

Hospital, institution, or street address where death occurred:
NO. #1

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For unborn infant, give residence of mother)

State MD County NicomisCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 2951 Fitzgwater
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Eminent Bounds

3. (b) Social Security Number

4. Sex

Male

5. Color of face

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Belle Bounds

7. Birth date of deceased (mo., day, yr.)

May 17-18746. (c) If alive, give age 65 years

8. AGE:

Years 73Months 6Days 2

If less than one day

hrs. min.

9. Birthplace

Nicomis Co. Md.
(Town, county, and state)

10. Usual occupation

Hatchman

11. Industry or business

William Bounds

12. Name

Nicomis Co. Md.

13. Birthplace

Maranda Cubes

14. Maiden name

Nicomis Co. Md.

15. Birthplace

Mrs. Belle Bounds

16. Informant

2951 Fitzgwater St. Salisbury Md

Address

Buried Nov. 21-1947

17. (Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematorium

Silvan Church Cem.

Location

Silvan Maryland

18. Funeral director

Hollman & Co. Walter R. Hollman

Address

Salisbury Maryland.

19. (Date rec'd by registrar)

11/21/47 H.C. Wallace, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19 1947, at 8⁰⁰ PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from medical 1947 to 1947and that I last saw person alive on 1947

Immediate cause of death

Coronary Occlusion

DURATION

sudden death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations noneDate of op. noneAutopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Nature of injury

Injured at work?

23. SIGNATURE

Expedienter M.D. or otherAddress Salisbury, Md Date signed 11/19/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line coverage is especially important. Physicians: please write the causes of death clearly and legibly

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DEC 6 1947
BUREAU OF

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 383

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

D.O.H.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 106 West
 (If rural, give LOCATION)

2.(a) If veteran, name war no

3. (a) FULL NAME

Brewington, Robert

3. (b) Social Security Number

214-10-8763

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

no6. (c) If alive, give age no years

7. Birth date of

deceased (mo., day, yr.)

1909

8. AGE:

Years

Months

Days

If less than one day

38626

.....hrs.

.....min.

9. Birthplace Salisbury, Wicomico, Maryland

(Town, county, and state)

10. Usual occupation

Presser

11. Industry or business

Cleaners & Pressers

FATHER

12. Name

Henry Purnell

13. Birthplace

Salisbury, Maryland

MOTHER

14. Maiden name

Alice Brewington

15. Birthplace

Salisbury, Maryland

16. Informant

Mrs. Alice Brewington

Address

106 West St. Salisbury, Maryland

17.

(Burial, cremation, or removal. Which?)

Date thereof

Dec. 4-47
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

402 E. Church St. Salisbury, Md.

19.

10/14/47
(Date rec'd by registrar)1947Barrie L. JohnsonLocal

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30th 1947, at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 24, 1947, to Nov. 30, 1947and that I last saw him alive on Nov. 26, 1947

Immediate cause of death

DURATION

Due to

Lobar PneumoniaWeek

Due to

BronchitisWeek

Other conditions

none

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Herbert S. Johnson
Salisbury, Md. M. D. or other
Date signed 12/2/47

RECEIVED

DEC 18 1947

BUREAU

Dr. Hosce

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

10452

CERTIFICATE OF DEATH

Reg. Dist. No. 260333

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital
How long in hospital or institution? 9 days, 9 hours, 15 mins.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Princess Anne
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Brittingham, Mr. Ray

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) June 23, 1885

8. AGE: Years Months Days If less than one day

62 4 15 hrs. min.9. Birthplace Somerset Co., Md.
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business _____

12. Name George H. Brittingham13. Birthplace Somerset Co., Md.14. Maiden name Sarah Riggins15. Birthplace Somerset Co., Md.16. Informant Mr. Harry BrittinghamAddress Princess Anne, Md. Rt. 117. Burial Date thereof Nov 9, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Rehobeth Meth. CemeteryLocation Rehobeth, Md.18. Funeral director Wilson Funeral HomeAddress Princess Anne, Md.19. 11/8 47 X. J. Johnson, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7th 19 47, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10/29 19 47, to 11/7 19 47.and that I last saw him alive on 11/7 19 47.Immediate cause of death CerebralDue to Chronic degenerative

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert Fisher, M.D.
M. D. or otherAddress Salisbury, Md. Date signed 11/9, 47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

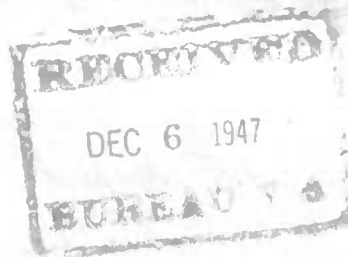
VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians; please write the causes of death clearly and legibly.

RECEIVED

NOV 11 1947

BUREAU V C



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

10454

CERTIFICATE OF DEATH

Reg. Dist. No. 1436

1. PLACE OF DEATH:

County WicomicoCity or town Seelma
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Seelma
(If outside city or town limits, write RURAL and give nearest town)Street No. 11 Chestnut
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Mary Calloway7. Birth date of deceased (mo., day, yr.) Aug 3, 19126.(c) If alive, give age 40 years8. AGE: Years 35 Months 5 Days 1 If less than one day hrs. min.9. Birthplace Salisbury Md
(Town, county, and state)10. Usual occupation Bldg11. Industry or business Penn. Railroad Co

FATHER

MOTHER

12. Name Wm F Calloway13. Birthplace Wicomico County, Md14. Maiden name Mary E. Hingate15. Birthplace Wicomico County, Md16. Informant Mary CallowayAddress Seelma, Del.17. (Burial, cremation, or removal, Which?) BurialDate thereof 11-5-47
(month) (day) (year)Cemetery or crematorium Gr & Olive Gr & CremLocation Seelma Del18. Funeral director W-S! Daniel CoAddress Seelma Del19. November 4th 1947
(Date rec'd by registrar)Registrar Harry E. Hudson

3. (b) Social Security Number

22201-6425

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 1947, at 8:35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. med cert alive on 11-3-47

Immediate cause of death

Cerebral Occlusion

DURATION

sudden death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following; N

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE Dr Rademaker MD

M. D. or other

Address Salisbury Md Date signed 11/4/47

RECEIVED

NOV 6 1947

6-8-47

Dr. C. Fisher

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

516

10455

CERTIFICATE OF DEATH

Reg. Dist. No. 339

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 10 days - 17 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 109 Catherine Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Cottman, Wallace

3. (b) Social Security Number

300-078160

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Anne Cottman

7. Birth date of deceased (mo., day, yr.)

yes

6. (c) If alive, give age

1890

8. AGE:

Years

Months

Days

If less than one day

13

hrs. min.

9. Birthplace

Princess Anne Md
(Town, county, and state)

10. Usual occupation

Labourer

11. Industry or business

Same as above

FATHER

12. Name

Wallace Cottman

13. Birthplace

Princess Anne

MOTHER

14. Maiden name

Lydia Cottman

15. Birthplace

Princess Anne

16. Informant

Lydia M. Bell

Address

Salisbury Md

17.

Burial

Date thereof

Dec 2 - 1947
(month) (day) (year)

Cemetery or crematory

West Port Office

Location

Princess Anne Md

18. Funeral director

James H. Stewart

Address

Salisbury Md

19.

18218

19.

J. P. Hester

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29th 19 47, at 4:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw him alive on 11/29 19 47

Immediate cause of death

Cerebral of Pontine

DURATION

same

Due to

Due to

Other conditions

Senility

(Include pregnancy within 3 months of death)

Major findings of operations

Cerebral of Pontine

Date of op.

12/1/47Autopsy results Cerebral of Pontine

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Edwin T. Fisher

M. D. or other

Address

Salisbury MdDate signed 11/29/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 8 1947

BY MAIL

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH Dr. Rademaker.
2411 N. Charles St., Baltimore
CERTIFICATE OF DEATH 94a

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico County
City or town Salisbury Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs
Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Wicomico Co
City or town Spring Hill Rd. Salisbury, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME

Arthur Crumley

3. (b) Social Security Number

219-07-7569

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male Cal. married

6. (b) Name of husband or wife Louise Crumley6. (c) If alive, give age — years7. Birth date of deceased (mo., day, yr.) Feb 15th 18998. AGE: Years Months Days If less than one day
48 hrs. min.9. Birthplace Tuskegee Ala
(Town, county, and state)10. Usual occupation Labrer11. Industry or business none12. Name Crawford Crumley13. Birthplace Ala14. Maiden name unknown15. Birthplace unknown16. Informant Louise CrumleyAddress Spring Hill Rd. Salisbury Md17. Buried Date thereof Dec 6 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Georgian Cemetery, Salisbury, Md.Location Georgian Cemetery, Salisbury, Md.18. Funeral director Booker M. WestAddress 715 1/2 Lake St. Salisbury Md19. 10/6 1947 Dr. Baggett Registrar

(Date recd. by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 1947, at 4³⁰ M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 to 10 and that I last saw him alive on Dec 6 1947Immediate cause of death Coronary atherosclerosisDURATION Cardiac deathDue to —Due to —Other conditions —

(Include pregnancy within 8 months of death)

Major findings of operations noneDate of op. noneAutopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: noAccident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE Medical Examiner M. D. or otherAddress Salisbury Md Date signed 12/1/47

RECEIVED
DEC 18 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

10456

337

Reg. Dist. No. 337

1. PLACE OF DEATH:

County Wilcomico
 City or town Gesterville, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Lifetime
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wilcomico
 City or town Gesterville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Eliya Frances Washields

3. (b) Social Security Number

4. Sex 7 5. Color or race col. 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife John Washields
 6.(c) If alive, give age 66 years
 7. Birth date of deceased (mo., day, yr.) May 10, 1894
 8. AGE: Years 53 Months 4 Days 17 If less than one day
 hrs. min.

9. Birthplace Gesterville, Wilcomico, Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
 12. Name Darry Syres
 13. Birthplace Washington, D. C.
 14. Maiden name Jane Conway
 15. Birthplace White Haven

16. Informant John Washields
 Address Gesterville, Md.

17. Burial Date thereof 11/30/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Gesterville Church Cem.

Location Gesterville, Md.

18. Funeral director C. S. Messick

Address Bivalve, Md.

19. Nov. 30 19 47 R. R. Wolford Walter
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1947, at 11:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6 1947, to Nov. 28 1947, and that I last saw him alive on Nov. 20 1947.

Immediate cause of death

Chronic myocarditis

DURATION

2 years

Due to

Cholecystitis6 mos.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide. Date of

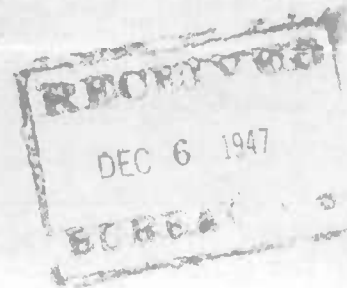
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. H. Lemble, M.D.
Schubert M.D. M.D. or other

Address Schubert M.D. Date signed 12/1/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

10457

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
 City or town Rural-Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Two Weeks
 Hospital, institution, or street address where death occurred:
Hilltop Convalescing Home
 How long in hospital or institution? Two Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Talbot Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

Henrietta Bothum Dashiell

3. (b) Social Security Number

- - - - -

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Charles Thomas Dashiell
(Died Dec. 1928) 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) Sept. 20, 1861
 8. AGE: Years 86 Months 1 Days 27 (If less than one day hrs. min.)

9. Birthplace Cornersville, Dor. Co., Md.
 (Town, county, and state)
 10. Usual occupation
 11. Industry or business

FATHER 12. Name George Bothum
 13. Birthplace Maryland
 MOTHER 14. Maiden name Elizabeth Mitchell
 15. Birthplace Maryland

16. Informant Mrs. Otis Dashiell
 Address Cambridge, Maryland.
 17. Burial Date thereof Nov. 26, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cambridge Cemetery
 Location Cambridge, Maryland
 18. Funeral director LeCompte's Funeral Service
 Address Cambridge, Maryland.

19. 11/26/47 Dr. Daniel E. Johnson
 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24, 1947 at 7:57P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 18 19 47 to Nov. 24 19 47
 and that I last saw her alive on Nov. 24 19 47

Immediate cause of death Cerebral Hemorrhage
Hypertension & Atherosclerosis
 Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Frederic R. Grams M.D. M. D. or other
 Address Salisbury, Md. Date signed 11/27/47

RECEIVED

DEC 8 1947

BUREAU V C

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

10458

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH

County McComieCity or town Pittsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

P.O. Box 81

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County McComieCity or town Pittsville
(If outside city or town limits, write RURAL and give nearest town)Street No. P.O. (Box 81)
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Ralph Herman Davis

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Addie Holloway Davis

7. Birth date of deceased (mo., day, yr.)

Nov. 25 - 18986. (c) If alive, give age 48 years

8. AGE:

Years

Months

Days

If less than one day

491128

hrs.

min.

9. Birthplace

Pittsville Md.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial, cremation, or removal (month) (day) (year)

18. Cemetery or place of burial

Location

19. Date of death

20. Registrar

21. Signature

22. Date signed

23. Address

24. Date of death

25. Date of death

26. Date of death

27. Date of death

28. Date of death

29. Date of death

30. Date of death

31. Date of death

32. Date of death

33. Date of death

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 1947 at 10:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 24 1947 to Nov. 23 1947and that I last saw him alive on Nov. 23 1947Immediate cause of death Cardiovascular renaldisorder

DURATION

10 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Cause of injury

Injured at work?

23. SIGNATURE

G. R. Wood

M. D. or other

Address

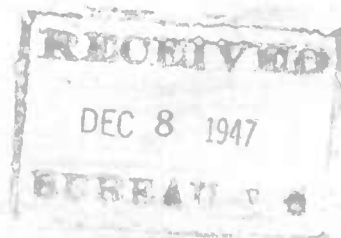
Wellsboro, Md.Date signed 11-25-47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE, WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County AccomackCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Annasula General HospitalHow long in hospital or institution? 7 hrs. 15 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarcesterCity or town Salisbury, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. Berlin
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Annas, Baby George Wayne

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

10 hrs. 25 min.9. Birthplace Berlin, Harcester, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Annas, George13. Birthplace Philadelphia, Pa.

MOTHER

14. Maiden name Schaefer, Dorothy15. Birthplace Wilmingon, Del.16. Informant George AnnasAddress Berlin, Md.17. Cremation
(Burial, cremation, or removal. Which?)Date thereof 11/19/47
(month) (day) (year)Cemetery or crematory Annasula General HospitalLocation Salisbury, Md.18. Funeral director Annasula General HospitalAddress Salisbury, Maryland19. 11/20/47
(Date read by registrar)H. C. Barnett, Jr.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18 19 47 at 1:55 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. - 18 19 47 to Nov. 18 19 47and that I last saw him alive on Nov. 18 19 47

Immediate cause of death

Prematurity

DURATION

10 hours

Due to

Due to

Other conditions

Bilateral Pulmonary atelectasis10 hours

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

airlines, M.D.Address Salisbury, Maryland Date signed 11/19/47

RECEIVED

DEC 5 1947

BUREAU

Dr. Gramse

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10460

Reg. Dist. No. 339

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 2 days - 7 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. P.R. #3 Mt. Herman Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Fahrenz, Mr. Peter

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Charlotte Fahrenz

7. Birth date of

deceased (mo., day, yr.)

April 3 - 1860

6. (c) If alive, give age in years

8. AGE:

Years

Months

Days

If less than one day

87715

hrs.

min.

9. Birthplace

Lake Huntington N.Y.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

Peter Fahrenz

13. Birthplace

Germany

14. Maiden name

Unknown

15. Birthplace

Germany

16. Informant

Mr. Frank Fahrenz

Address

P.O. #3, Salisbury Md

17.

(Burial, cremation, or removal, Which?)

Date thereof

Nov. 22-47
(month) (day) (year)

Cemetery or crematory

Forest Grove Cema

Location

Near Plumbers Ind

18. Funeral director

Hallway & C. R. Hall

Address

Salisbury Maryland

19.

(Date rec'd by registrar)

19.

Dr. Harriet A. JohnsonSeal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18th 19 47 at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 19 47 to Nov 18 19 47and that I last saw him alive on Nov 18 19 47

Immediate cause of death

Heart

DURATION

Due to

Prostatic obstruction

Due to

Other conditions

Acute lymphaticleukemia
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

22. SIGNATURE

Dr. P. Gramse M.D.

M. D. or other

Address

Salisbury, MdDate signed 11/19/47

MARGIN RESERVED FOR FOLDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 6 1947
67 R 2 10 0 2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:

County Wilcomilo
 City or town Salisbury md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? no
 Hospital, institution, or street address where death occurred: no
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Wilcomilo
 City or town Salisbury md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 404 Lake St
 (If rural, give LOCATION) no
 2.(a) If veteran, name war no

3. (a) FULL NAME

George Furness
 4. Sex MALE 5. Color or race white 6.(a) Single, married, widowed, or divorced married

3. (b) Social Security Number

no

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20 19 47, at 9:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15 19 46, to Nov 20 19 47
 and that I last saw him alive on Nov 20, 19 47

Immediate cause of death Coronary Thrombosis DURATION 15 min

Due to Atherosclerosis 12 min

Due to no

Other conditions no

(Include pregnancy within 3 months of death)

Major findings of operations no Date of op. no

Autopsy results no
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of no

Where did injury occur? no (City or town) no (County) no (State)

Injured at home, farm, industry, public place (where?) no

Means of Injury no Injured at work? no

23. SIGNATURE E. A. Furness, M.D. M. D. or other no
 Address 200 W. Main St. Salisbury Date signed 11/24/47

8. AGE: Years Months Days If less than one day

about 89 (about) no hrs. no min.

9. Birthplace Somerset County (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Same as above

12. Name unborn

13. Birthplace unborn

14. Maiden name Leah Shields

15. Birthplace Boals Road Somerset Co

16. Informant Mrs Vera Wright

Address Salisbury md

17. Burial Date thereof Nov 24-1947
 (Burial, cremation, or removal, Where?) (month) (day) (year)

Cemetery or crematory Green Ales

Location Salisbury md

18. Funeral director James Stewart

Address Salisbury md

19. 11/24/47 19 47 E. A. Furness Registrar

(Date rec'd by registrar)

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1

RECEIVED
DEC 6 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1700

10462

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town En route to Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Leonard Thomas Guthrie Jr.
Guthrie, Leonard Jr

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Jan. 5th 1933

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

14102

hrs.

min.

9. Birthplace

Philadelphia Pa.
(Town, county and state)

10. Usual occupation

School Boy

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

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RECEIVED

DEC 8 1947

STRENGTH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47d

10463

CERTIFICATE OF DEATH

Reg. Dist. No. 939

1. PLACE OF DEATH: *Wicomico*
 County *Salisbury*
 City or town *Salisbury*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *5 years*
 Hospital, institution, or street address where death occurred:
104 W. Phila. Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State *Md.* County *Wicomico*
 City or town *Salisbury*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *104 W. Phila. Ave.*
 (If rural, give LOCATION)
 2.(a) if veteran, name war

3. (a) FULL NAME *Linwood Frederick Howard* 3. (b) Social Security Number

4. Sex *Male* 5. Color or type *White* 6.(a) Single, married, widowed, or divorced *Married*
 6.(b) Name of husband or wife *Grace B. Howard*
 6.(c) If alive, give age *40* years
 7. Birth date of deceased (mo., day, yr.) *July 11-1895*
 8. AGE: Years *52* Months *4* Days *2* If less than one day
 hrs. min.

9. Birthplace *Laurel Delaware*
 (Town, county, and state)

10. Usual occupation *Salesman*

11. Industry or business *Electrical Supplies*

12. Name *William Howard*

13. Birthplace *Laurel Delaware*

14. Maiden name *Albetta*

15. Birthplace *Laurel Delaware*

16. Informant *Mr. Grace B. Howard*

Address *104 W. Phila. Ave. Salisbury Md.*

17. *Burial* Date thereof *Nov 15-1947*
 (Burial, cremation, or disposal, Which?) (month) (day) (year)

Cemetery or crematory *Wicomico Mem. Park*

Location *Salisbury, Maryland*

18. Funeral Director *Fuller & Co. Walter R. Fullmer*

Address *Salisbury, Maryland*

19. *11/15-47* Registrar *W. Barrett & John*

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *Nov. 13th 1947* at *245 P*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *March 10, 1947* to *Nov 13, 1947*
 and that I last saw him alive on *Nov 13, 1947*

Immediate cause of death *Carcinoma of lungs with metastases to brain*
 DURATION *(?)*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

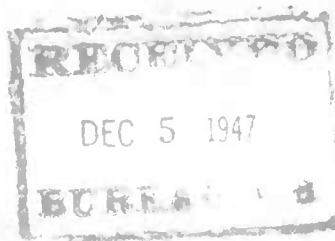
23. SIGNATURE *John H. Keaman M.D.* M. D. or other

Address *228 Camden Ave.* Date signed *11-13-47*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10464

Reg. Dist. No. 333

1. PLACE OF DEATH

County... Pennsylv. General Hospital
 City or town... Salisbury, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Pen. Gen. Hospital
 How long in hospital or institution? 30 hrs.

3. (a) FULL NAME

Hudson, Baby Wayne Thomas.

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Oct. 17, 1947

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

30 hrs. min.

9. Birthplace

Midford, Del.
 (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial, cremation, or removal, which?

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date signed by registrar

20. Date signed

21. Date signed

22. Date signed

23. Date signed

24. Date signed

25. Date signed

26. Date signed

27. Date signed

28. Date signed

29. Date signed

30. Date signed

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Frankford, Del.
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

16 November 1947 at 10:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

15 November 1947 to 16 Nov. 1947

and that I last saw him alive on 16 November 1947

Immediate cause of death

(1) Rt. upper lobar pneumonia

DURATION

48 hrs.

Due to

(2) Acute glomerulo-nephritis

unknown

Due to

(3) Infectious diarrhea

2 weeks

Other conditions

(1) malnutrition

2 weeks

(2) Dehydration

2 weeks

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

24. SIGNATURE

Address

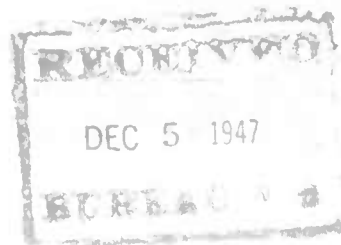
Date signed

Andrew M. D.

M. D. or other

Salisbury, Md.

11/17/47



10465

Reg. Diat. No. 333

1. PLACE OF DEATH: *St. Louis, Mo.*
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
415. Olive St. (Bright Nursing Home)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For a newborn infant, give residence of mother)
State.....*Mo.* County.....*St. Louis*
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No. *415* (If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME	Pearl Lammore	3. (b) Social Security Number	
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4. Sex <i>Female</i>	5. Color or race <i>White</i>	6. (a) Single, married, widowed, or divorced <i>Widow</i>	MEDICAL CERTIFICATION 2D. DATE OF DEATH <i>Nov. 1st</i> 19 <i>47</i> at <i>7:45</i> 2F. I CERTIFY that death occurred on the date above stated; that I attended deceased from <i>10-25-47</i> 19 <i>47</i> to <i>11-1-47</i> 19 <i>47</i> and that I last saw h. <i>a</i> alive on <i>11-1-47</i> 19 <i>47</i> Immediate cause of death Duration	
6. (b) Name of husband or wife <i>William Harmon</i>			6. (c) If alive, give age <i>Deaf</i> years	
7. Birth date of deceased (mo., day, yr.) <i>Oct. 30 - 1881</i>				

8. AGE:	Years	Months	Days	If less than one day	Immediate cause of death	Duration
66		0	1	hrs. min.	Cerebral Occlusion	17 days

9. Birthplace: Birahie Maryland
(Town, county, and state)

Due to: Arterio sclerosis

10. Usual occupation..... *at home* Due to.....

12. Name William P. Foreman Other conditions Hypertension

13. Birthplace Iowa, Chapman (Include pregnancy within 3 months of death)

14. Maiden name Mary Jordan Major findings of operations

16. Signature of Maryland
Mr. Thomas Garrett

16. Informant 32 N. Pollock zone 24 Balls Bluff
 Address 32 N. Pollock zone 24 Balls Bluff
 City St. Louis State Mo. Zip 63108
 Telephone 314-435-1111
 Date 11/1/83
 22. VIOLENCE: It death was due to external causes, fill in the following:
 Cause None
 Manner None
 Place None
 Circumstances None
 Physician: Please underline the cause to which death should be charged statistically.

17. Burial Date thereof Nov. 3-71
(Burial, cremation, or removal. Which?) (month) (day) (year)

Accident, suicide, or homicide. Date of

Where did injury occur?

Cemetery or crematory *Beverly Maryland.* (City or town) (County) (State)
Location *Beverly Maryland.* Injured at home, farm, industry, public place (where?)

18. Federal director	Hollman, G. Walter R. Hollman	Means of injury	Injured at work?

Address 11/5-18 23. SIGNATURE H. P. ... M. D. or other 11-1-4

(Data rec'd by registrar) *1/1/11* Registrar *1/1/11* Address *1/1/11* Date signed *1/1/11*

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the event age is especially important. Physicians: please write the causes of death clearly and legibly.

RECORDED
NOV 24 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In contact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 338

1. PLACE OF DEATH

County SalisburyCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:
RD. #3

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For children infants give residence of mother)

State Md. County SalisburyCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. RD. #3
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Selby Burton Marvel

3. (b) Social Security Number

4. Sex

Male

5. Color of race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Pearl Marvel

7. Birth date of deceased (mo., day, yr)

Oct. 19-1868

6. (c) If alive, give age years

8. AGE:

Years 79

Months

1

Days

0

It less than one day

hrs. min.

9. Birthplace

Russell G. Delaware
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Farmer

MOTHER

FATHER

12. Name

James B. Marvel

13. Birthplace

Russell G. Del.

14. Maiden name

Mary E. Love

15. Birthplace

Russell G. Del.

16. Informant

Mr. Pearl Marvel

Address

RD. #3, Salisbury Md.

17. Burial

Chapin Cemetery
(Burial, cremation, or removal, which?)

Cemetery or mortuary

RD. Salisbury Md.

Location

William + G. Walter R. Williams

18. Funeral director

Salisbury Maryland

Address

11/23/47

(Date rec'd by registrar)

19. Registrar

W. H. Haggard

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1947 at 8 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Inf 1942 to Nov 19 1947and that I last saw him alive on Nov 19 1947Immediate cause of death Pericardial ConstrictionDue to Chronic NephritisDue to Chronic Nephritis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE J. H. Haggard

M. D. or other

Address Salisbury Md.Date signed Nov 20 1947

RECEIVED
DEC 6 1947
BUREAU V.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 999

1. PLACE OF DEATH:

County Wilcomico
 City or town Salisbury Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Four years
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution? Two weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Wilcomico
 City or town Salisbury Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Plato Valley 212
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Glen Mason

3. (b) Social Security Number

245-34-7633

4. Sex male 5. Color or race Q.A. 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Sophia Mason
 7. Birth date of deceased (mo., day, yr.) Dec 24 1904 6.(c) If alive, give age 38 years
 8. AGE: Years 43 Months - Days - It less than one day - hrs. - min.

9. Birthplace Advente N.C.
(Town, county, and state)10. Usual occupation Laborer11. Industry or business Same as above12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Mr. Sophia MasonAddress Salisbury Md17. Burial Date thereof Jan 8-1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory HanstonLocation Salisbury Md18. Funeral director James P. StewartAddress Salisbury Md19. 1/8 19 48 Parazit Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 19 47 at - M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-12 19 47 to Dec 31 19 47and that I last saw him alive on Dec 31 19 47Immediate cause of death Encephalitis (Leuence) DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Phyllis Smith M. D. or otherAddress Salisbury Md Date signed 1-2-48

RECEIVED

FEB 2 1948

STILL

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 10467
 Reg. Dist. No. 338

1. PLACE OF DEATH:

 County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Remondale General HospitalHow long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Del. County LaurelCity or town Laurel
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mason Mr. Thomas L.

3. (b) Social Security Number

Name

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Mason Mrs. Ethel

7. Birth date of

deceased (mo., day, yr.)

Apr. 3, 1862

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

8577

hrs.

min.

9. Birthplace

Delaware
(Town, county, and state)

10. Usual occupation

Druggist

11. Industry or business

FATHER

12. Name

Levin T. Mason

13. Birthplace

Delaware

MOTHER

14. Maiden name

Mary Jane Mason

15. Birthplace

Delaware

16. Informant

Mrs. Ethel Mason

Address

Laurel Del

17.

(Burial, cremation, or removal. Which?)

Date thereof

Nov. 13, 47
(month) (day) (year)

Cemetery or crematory

Laurel Delaware

Location

18. Funeral director

G. J. Quessy

Address

Laurel Del

19.

(Date filed by registrar)

11/18/47

H. P. Barrett

S. J. Phelan

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10, 1947 at 5:18 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 2, 1947 to Nov. 10, 1947and that I last saw him alive on Nov. 9, 1947

Immediate cause of death

Myocardial insufficiency 2 month

DURATION

Due to Coronary Artery Disease 5 monthwith Coronary ThrombosisDue to Atherosclerosis 5 daysOther conditions Anemia due tonephrosclerosis [6/47 also]

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

David J. Gilmore M.D.
Address Salisbury, Ind. Date signed Nov. 19, 1947

M. D. or other

RECEIVED
DEC 8 1947
BUREAU

Dr. Noek

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

122a

B 10468
Reg. Dist. No. 333

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 days
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution? 4 days - 20 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State DELAWARE County Dorsey
 City or town Delmar
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 804 Grove Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war. ☒

3. (a) FULL NAME

MOORE, Mr. Charles R.

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife Mrs. Nella Moore
 6. (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) August 21, 1888.

8. AGE: Years 59 Months 3 Days 3 It less than one day hrs. min.

9. Birthplace Sussex Co. Delaware
 (Town, county, and state)

10. Usual occupation Picket Collector

11. Industry or business Perry, R.R.

12. Name William N. Moore

13. Birthplace Sussex Co., Delaware.

14. Maiden name Maudie C. Steele

15. Birthplace Sussex Co., Delaware.

16. Informant Mrs. Charles R. Moore

Address Grove St., Delmar, Del.

17. Burial, cremation, or removal, Which? Burial Date thereof 11/26/47
 (month) (day) (year)

Cemetery or crematory Mt. Olive

Location Delmar, Delaware.

18. Funeral director De Wille & Johnson Co.

Address Salisbury, Md.

19. 11/26/47 19 47 W. N. Moore Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 19 47 at 6:52 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/19 19 46 to 11/24 19 47
 and that I last saw him alive on 11/24/47 19 47

Immediate cause of death Shingles to heart
18 yrs. cancer + leukemia

Due to Shingles to heart
18 yrs. cancer + leukemia

Due to Shingles to heart
18 yrs. cancer + leukemia

Other conditions Shingles to heart
18 yrs. cancer + leukemia

(Include pregnancy within 8 months of death)
 Major findings of operations Shingles to heart
 Date of op. 11/19/47

Autopsy results Shingles to heart
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

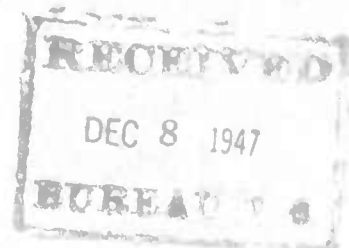
22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide 1 Date of 11/24/47
 Where did injury occur? 1 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE W. N. Moore
 M. D. or other W. N. Moore
 Address Salisbury, Md. Date signed 11/24/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

10469

CERTIFICATE OF DEATH

Reg. Dist. No. 338

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For those whose infants have residence of mother)
State Wicomico County Salisbury

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 309 Naylor street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Edward Clayton Munyon

3. (b) Social Security Number

4. Sex

Male

5. Color of face

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Lillie A. Munyon

7. Birth date of deceased (mo., day, yr.)

Dec. 2nd 1863

6. (c) If alive, give age

76 years

8. AGE:

Years 83 Months 11 Days 18 If less than one day
hrs. min.

9. Birthplace

Paulstown, N.J.
(Town, county, and state)

10. Usual occupation

retired

11. Industry or business

grocerman

12. Name

Charles Munyon

13. Birthplace

New Jersey

14. Maiden name

Rachel

15. Birthplace

New Jersey

16. Informant

Mrs. Lillie A. Munyon

17. Address

304 Naylor St. Salisbury

18. Burial

Buried in First Church Cem.

19. Cemetery or crematory

New Whiteville Delaware

20. Location

Wilmington Co. Witten R. Freeman

21. Funeral director

Salisbury Maryland

22. Address

11/22/1947

23. Date rec'd by registrar

11/22/1947

24. Registrar

Charles E. Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20th 1947 at 11:00 p

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-1940 to 11-20 1947and that I last saw him alive on 11-19 1947

Immediate cause of death

Acute cardiac failure

DURATION

Due to

Chronic Myocarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Injured at work?

23. SIGNATURE Charles E. Johnson

M.D. or other

Address Date signed

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DEC 6 1947

BUREAU V 6

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11

1. PLACE OF DEATH:

County WicomicoCity or town Delmar
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 60 yearsHospital, institution, or street address where death occurred:
206 Chestnut Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Delmar
(If outside city or town limits, write RURAL and give nearest town)Street No. 206 Chestnut
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Lillie Francis Nichols

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Charles Nichols7. Birth date of deceased (mo., day, yr.) Mar. 1, 1870

8. (c) If alive, give age -- years

8. AGE: Years 77 Months Days If less than one day
hrs. min.9. Birthplace Wicomico County, Md.
(Town, county, and state)10. Usual occupation House Work11. Industry or business Home12. Name Samuel A. Gordy13. Birthplace Wicomico County, Md.14. Maiden name Jane Rounds15. Birthplace Wicomico County, Md.16. Informant Stella NicholsAddress Delmar, Del.17. Burial Date thereof Nov. 25-47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt Olive MethodistLocation Delmar, Delaware18. Funeral director W. S. Emanuel CoAddress Delmar, Delaware19. Nov. 25, 1947 Harry E. Hudson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23, 1947, at 11:40 A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 10, 1947, to Nov. 23, 1947and that I last saw her alive on Nov. 23, 1947Immediate cause of death Cerebral hemorrhagewith at side paralysis withparalysis of right arm & legDue to hypertension & atherosclerosisof atherosclerosisDue to chronic nephritis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Injured at work?

Means of injury

23. SIGNATURE J. H. Lynch M. D. or otherAddress Delmar, Del. Date signed Nov. 26, 1947

MARGIN RESERVED FOR BINDING

9-45-15M

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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NOV 26 1947



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11337

1. PLACE OF DEATH:

County Wicomico
City or town Pontiloke and
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Wicomico
City or town Pontiloke and
(If outside city or town limits, write RURAL and give nearest town)
Street No. no
(If rural, give LOCATION)
2. (a) If veteran, name war no

3. (a) FULL NAME

Edward G. Kuttler

3. (b) Social Security Number

no

4. Sex male 5. Color or race a.a. 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Hattie M. Kuttler

7. Birth date of deceased (mo., day, yr.) Aug 18 1870 6. (c) If alive, give age no years

8. AGE: Years about 70 Months no Days no If less than one day no hrs. no min.

9. Birthplace Pontiloke
(Town, county, and state)

10. Usual occupation Cyberman

11. Industry or business Same as above

12. Name Hezekiah Kuttler

13. Birthplace Pontiloke

14. Maiden name Leah Jane Washell

15. Birthplace Pontiloke

16. Informant Mr. Hattie M. Kuttler

Address Pontiloke and

17. Burial Date thereof Nov 21 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Pontiloke

Location Pontiloke and

18. Funeral director James G. Stewart

Address Pontiloke and

19. Nov 19 19 47 R. M. Kuttler
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 November 1947 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 April 1947 to 18 November 1947

and that I last saw h. no alive on 17 November 1947

Immediate cause of death Intestinal obstruction & ecchymosis DURATION 2 weeks

Due to Carcinoma Large Intestine ?

Due to no

Other conditions no

(Include pregnancy within 3 months of death)

Major findings of operations no Date of op. no

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of no

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) no

Means of injury no Injured at work? no

23. SIGNATURE Richard H. Saunders, M.D. M. D. or other no

Address Pontiloke, Md Date signed 19 Nov 47

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DEC 6 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital
 How long in hospital or institution? 14 days - 19 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For non-veteran infants give residence of mother)

State Md. County Wicomico
 City or town Salmon
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 406 Elizabeth Street
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

PARKS, Mr. James

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

Ella V. Parker

7. Birth date of deceased (mo., day, yr.)

Oct. 10 - 1876

6. (c) If alive, give age

66 years

8. AGE:

Years

Months

Days

If less than one day

7119hrs.min.

9. Birthplace

Nantuxen Md.
(Town, county, and state)

10. Usual occupation

Produce Dealer

11. Industry or business

Fruit Business

FATHER

12. Name

Thomson Parks

13. Birthplace

Nantuxen, Md.

MOTHER

14. Maiden name

Sarah King

15. Birthplace

Nantuxen, Md.

16. Informant

Mr. Ella V. Parker

Address

406 Elizabeth St. Salmon Md.

17. Burial, cremation, or removal. Which?

Buried

Date thereof

Nov. 21 - 47

Cemetery or crematory

Wicomico Mem. Park

Location

Salisbury Maryland

18. Funeral director

William R. Williams

Address

Salisbury Maryland

19. Date rec'd by registrar

11/21/47

20. Date of death

November 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 2 1947 to Nov 9 1947

and that I last saw him alive on

Nov 19 1947

Immediate cause of death

Hypertensive Pulmonary

Due to

Coronary Thrombosis

Due to

1 hr

Other conditions

None

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1948 19 47 at 5:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 2 1947 to Nov 9 1947and that I last saw him alive on Nov 19 1947

Immediate cause of death

Hypertensive PulmonaryDue to Coronary ThrombosisDue to 1 hrOther conditions None

(Include pregnancy within months of death)

Major findings of operations

NoneDate of op. Nov 6 1947

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? Salisbury (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

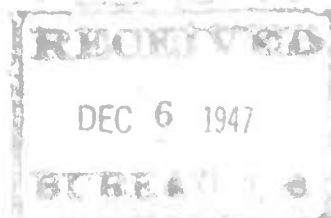
Means of injury

Injured at work?

23. SIGNATURE W. R. Williams

M. D. or other

Address SalisburyDate signed 11/21/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Yeaman

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10473

CERTIFICATE OF DEATH

Reg. Dist. No. 933

1. PLACE OF DEATH

County McComieCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street Address where death occurred:
RD. #3

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State Md County McComieCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. RD #3
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Cleora P. Parsons

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

George Samuel Parsons

7. Birth date of deceased (mo., day, yr.)

May 30-18786. (c) If alive, give age 79 years

8. AGE:

69 Years 5 Months 28 Days hrs. in.

9. Birthplace

RD. Parsonburg Md.
(Town, county, and state)

10. Usual occupation

Home wife

11. Industry or business

at home

12. Name

George Benjamin Parker

13. Birthplace

RD. Parsonburg Md.

14. Maiden name

Martha Jane Parsons

15. Birthplace

Prinville Md.

16. Informant

Mr. Geo. S. Parsons

Address

RD #3 Salisbury Md

17. (Burial, cremation, or removal, Which?)

Burial

18. Cemetery or crematory

Parsonburg Cem.

Location

Salisbury Md

19. (Date rec'd by registrar)

11/24/47

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 24 1947 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 20 1946 to Nov 24 1947and that I last saw him/her alive on Nov 24 1947

Immediate cause of death

Carcinoma of Stomachwith cerebral metastases

Due to

metastases

Due to

metastases

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

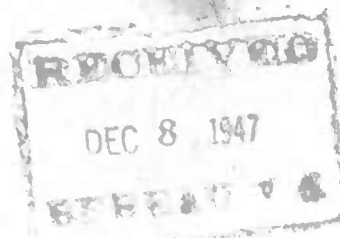
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John H. Yeaman M.D.Address 238 Camden AveDate signed 11/24/47



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians; please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

10474

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
1014 E. Church, St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Wicomico

City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1014 E. Church, St.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Catherine Peace

3. (b) Social Security Number

4. Sex

Female

5. Color of race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Theodore Peace

7. Birth date of deceased (mo., day, yr.)

Aug 11-1876

6. (c) If alive, give age years

Dead

8. AGE:

Years 71 Months 2 Days 28
 If less than one day hrs. min.

9. Birthplace

Salisbury Md.

10. Usual occupation

at home

11. Industry or business

John J. Corner

MOTHER

12. Name Christine13. Birthplace Christiansburg Va.14. Maiden name Mary Jane Mumford15. Birthplace Salisbury Md.16. Informant Miss William PeaceAddress 1014 E. Church St. Salisbury Md.17. (Burial, cremation, or removal. Which?) BuriedDate thereon Nov. 11-47Cemetery or crematory Parson's Cem.Location Salisbury Md.18. Funeral director John W. & C. Walter R. JohnsonAddress Salisbury Md.19. (Date filed by registrar) 11/11/47Registrar John W. & C. Walter R. Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 1947 at 472 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1942 to Nov 9 1947and that I last saw him alive on Nov 9 1947

Immediate cause of death

Acute cardiac failureDue to Chronic myocarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Philip R. Lusk

M. D. or other

Address Salisbury Md. Date signed 11-10-47

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NOV 22 1947
BUREAU F.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and fully.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10475

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Thames
 City or town Salisbury Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr.
 Hospital, institution, or street address where death occurred:
1 yr.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Thames
 City or town Salisbury Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Mary Perkins

3. (b) Social Security Number

4. Sex Female 5. Color or race col 6. (a) Single, married, widowed, or divorced widowed
 6. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 42 Months _____ Days _____ It less than one day _____ hrs. _____ min.

9. Birthplace Richmond Va.
 (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business none

12. Name John Waller

13. Birthplace Va.

14. Maiden name unknown

15. Birthplace Va.

16. Informant Madeline Nutter

Address Salisbury Md.

17. Burial Date thereof Nov. 5 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Green acres mem. park

Location West Rd. Salisbury Md.

18. Funeral director Booker M. West

Address Salisbury Md.

19. 11/5 19 47 Registrar W. H. Harrison

(Date by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-2 19 47 at 7:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 21 19 47 to Nov. 21 19 47

and that I last saw him alive on Nov. 2 19 47

Immediate cause of death Pneumonia DURATION 4 days

Due to Cardiac Failure (arteriosclerosis)

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE E. A. Farnell M. D. or other _____

Address 800 W. Main Date signed 11-5-47

RECEIVED

NOV 24 1947

BUREAU

RECEIVED

NOV 24 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

10476

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Helena
City or town Helena
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD. County Wiggin
City or town Helena MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary Ida Phippin

3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Henry Phippin
7. Birth date of deceased (mo., day, yr.) June 16, 1883 6.(c) If alive, give age 59 years

8. AGE: Years 64 Months 4 Days 19 If less than one day _____ hrs. _____ min.

9. Birthplace Malde Spring, Virginia
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Eugene Bailey

13. Birthplace Malde Spring, Md.

14. Malde same Malde Spring, Md.

15. Birthplace Malde Spring, Md.

16. Informant Henry Phippin
Address Helena, Md.

17. Burial Burial Date thereof 11/5/47
(Burial, cremation, or removal, which) (day) (year)

Cemetery or crematory Helena Cemetery

Location Helena, Md.

18. Funeral director David F. Neysch
Address Helena, Md.

19. 11/5 19. 47 Registrar David F. Neysch

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2, 1947 at 11:11 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 20th 1947 to November 2, 1947 and that I last saw him alive on November 2, 1947

Immediate cause of death Carcinoma of Breast

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE William E. Smith M. D. or other _____
Address Helena, Md. Date signed Nov 2-47

MARGIN RESERVED FOR BINDING

I

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DEPARTMENT OF JUSTICE

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NOV 24 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13/a

10477

CERTIFICATE OF DEATH

Reg. Dist. No. 939

1. PLACE OF DEATH:

County Wilcomilla
 City or town Salisbury and
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred: no
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MD County Wilcomilla
 City or town Salisbury and
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 124 Bellevue
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Leven W. Pinkett

3. (b) Social Security Number

no

4. Sex

Male

5. Color or race

a. g.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Katherine Pinkett

7. Birth date of deceased (mo., day, yr.)

Yes

6. (c) If alive, give age

Don't know

8. AGE:

65

Years

5

Months

11

Days

1882

It less than one day

hrs. min.

9. Birthplace

Packawalkin md
 (Town, county, and state)

10. Usual occupation

Miner

11. Industry or business

Same as above

12. Name

Leven W. Pinkett

13. Birthplace

Packawalkin

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Dr. Katherine Pinkett

Address

Salisbury MD

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

Nov. 13, 1947

(month) (day) (year)

Cemetery or crematory

Houn Abers

Location

Salisbury and

18. Funeral director

Samuel Stewart

Address

Salisbury MD

19. (Date rec'd by registrar)

11/15/47

19. 47

Barrett G. Johnson

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 13

19. 47

at 6:30 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Nov. 23

19. 46

to Nov. 13

19. 47

and that I last saw h. alive on Nov. 12

19. 47

Immediate cause of death

Cardio-vascular renal

Syndrome

Due to

glomerular nephritis and

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

no

Autopsy results

no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide..... Date of.....

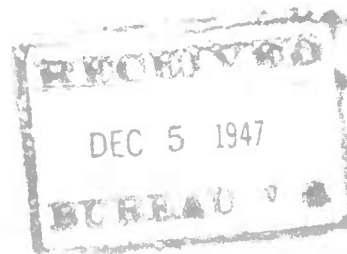
Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE Harrell M.D.

Address PO Box 1000, Salisbury, MD Date signed 11/14/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

106 &

10478

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: *Wicomico*
County *Salisbury*
City or town *Salisbury*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *124. Lincoln Ave*
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For new born infants give residence of mother)
State *Md* County *Wicomico*
City or town *Salisbury*
(If outside city or town limits, write RURAL and give nearest town)
Street No. *124. Lincoln Ave*
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME *Charlie Edward Pruitt*

3. (b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*
6. (b) Name of husband or wife *Sarah F. Pruitt*
7. Birth date of deceased (mo., day, yr.) *July 8th 1883*
6. (c) If alive, give age *57* years
8. AGE: Year *64* Months *40* Days *9* It less than one day *hrs. min.*

9. Birthplace *Worcester County, Md.*
(Town, county, and state)
10. Usual occupation *Night Watchman*

11. Industry or business *Charlie William Pruitt*

12. Name *Worcester Co. Maryland*

13. Birthplace *Julia Outten*

14. Maiden name *Worcester Co. Maryland*

15. Birthplace *Mrs Sarah F. Pruitt*

16. Informant *124 Lincoln Ave. Salisbury Md*

17. Burial Date thereof *Nov. 19-1947*
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory *Wicomico Mem. Park*
Location *Salisbury Maryland*
18. Funeral director *Walter R. Hollings*
Address *Salisbury Maryland*

MEDICAL CERTIFICATION
20. DATE OF DEATH *Nov. 17th 1947* at *49*
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Nov. 16* 19 *47* to *Nov. 17* 19 *47*
and that I last saw him alive on *Nov. 17* 19 *47*
Immediate cause of death *Myocardial Insufficiency* DURATION *2 months*
Due to *Cor pulmonale* *10 yrs.*
Due to *Chronic Bronchitis*
Pulmonary emphysema
Other conditions

(Include pregnancy within 3 months of death)
Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE *David L. L. L.*
M. D. or other
Address *Salisbury Md* Date signed *Nov. 18, 1947*

19. *11/19/47* 19 *47* *Walter R. Hollings*
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 5 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

930

10480

CERTIFICATE OF DEATH

Reg. Dist. No. 939

1. PLACE OF DEATH:

County... Wilcoming
 City or town... Delmar (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Wilcoming 28 years
 Hospital, institution, or street address where death occurred: no
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... MD County... Wilcoming
 City or town... Delmar MD RPO No 3 (If outside city or town limits, write RURAL and give nearest town)
 Street No... no (If rural, give LOCATION)
 2.(a) If veteran, name war... no

3. (a) FULL NAME

Frank Roach

3. (b) Social Security Number

4. Sex male 5. Color or race aa 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Julia Roach

7. Birth date of deceased (mo., day, yr.) Nov 26, 1893 6. (c) If alive, give age known years

8. AGE: Years 34 Months 11 Days 16 If less than one day hrs. min.

9. Birthplace... Seaford Del. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business same as above

12. Name John Roach

13. Birthplace Seaford Del

14. Maiden name Gennie Sardin

15. Birthplace Seaford Del

16. Informant Mrs. Julia Roach

Address Delmar RPO No 3

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 19, 1947 (month) (day) (year)

Cemetery or crematory Federalburg and

Location Federalburg Md

18. Funeral director James H. Stewart

Address Federalburg Md

19. 11/19/47 (Date rec'd by registrar) Registrar David J. Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH... Nov 16 19 47 at 6:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-26-47 19 47, to 11-16 19 47

and that I last saw him alive on 11-16 19 47

Immediate cause of death Bulbar Apoplexy DURATION 6 days

Due to Renal Hypertension 12 months

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Purnell, M.D. M. D. or other cap

Address... 11-18-47 Date signed

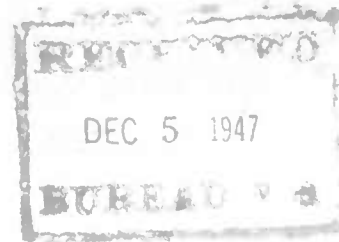
MARGIN RESERVED FOR BINDING

1-7

VS A15 9-45:15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:

County Wicomico
 City or town Fruitland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Working hours - 5 months
 Hospital, institution, or street address where death occurred: Dulaney Packing Co
 How long in hospital or institution? 3

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Somerset
 City or town Rural Fairmount
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____ ✓

3. (a) FULL NAME

Revelle, Bain Keenan

3. (b) Social Security Number

unknown

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) September 29, 1917
 8. AGE: Years 30 Months 1 Days 5 It less than one day _____ hrs. _____ min.

9. Birthplace Fairmount Somerset Maryland
 (Town, county, and state)

10. Usual occupation Factory Worker

11. Industry or business Canning

12. Name Robert Bain Revelle

13. Birthplace Fairmount, Md

14. Maiden name Jean B. Keenan

15. Birthplace England

16. Informant Robert Bain Revelle

Address Fairmount, Md

17. Burial Date thereof Nov. 7, 1947

(Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory Fairmount Methodist Cem.

Location Fairmount, Md.

18. Funeral director H. Horsey Bradshaw

Address Crisfield, Md.

19. 11/7/47 Registrar

(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 4 19 47, at 11:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death coronary occlusion DURATION sudden death

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations None

Autopsy results None Date of op. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

Signature LaRadenaher MD M. D. or other _____

Address Chesbury Md Date signed 11/7/47

AMERICAN COUNCIL
ON UNEMPLOYMENT

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NOV 24 1947

BUREAU V

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462

10481

CERTIFICATE OF DEATH

Reg. Dist. No. 393

1. PLACE OF DEATH:

County Kiowa
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 49 years
 Hospital, institution, or street address where death occurred:
700 Broad St.
 How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Kiowa
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 700 Broad St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war ✓

3. (a) FULL NAME

Mary Virginia Smith

3. (b) Social Security Number

✓

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife ✓
 7. Birth date of deceased (mo., day, yr.) June 25, 1874
 8. AGE: Years 73 Months 4 Days 11 If less than one day hrs. min.

9. Birthplace Kiowa Co., Md.
 (Town, county, and state)
 10. Usual occupation Retired
 11. Industry or business Milliner
 12. Name Mary V. Smith
 13. Birthplace Kiowa Co., Md.
 14. Maiden name Mary C. Phillips
 15. Birthplace Kiowa Co., Md.

16. Informant Miss Ruth Smith
 Address 700 Broad St., Salisbury, Md.
 17. Burial Date thereof 11/8/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Parsons
 Location Salisbury, Md.
 18. Funeral director The Bell & Johnson Co.
 Address Salisbury, Md.

19. 11/11/47 Registrar H. H. Haggard
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 1947 at 4:20 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 3, 1947 to Nov. 5, 1947
 and that I last saw him alive on Nov. 5, 1947

Immediate cause of death Carcinoma of the Colon
 DURATION 5 hours

Due to —
 Due to —

Other conditions Advanced
arteriosclerosis
 (Include pregnancy within 3 months of death)

Major findings of operations —
 Date of op. —

Autopsy results —
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide — Date of —
 Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —
 Means of injury — Injured at work? —

23. SIGNATURE David L. Haggard, D.D.
 Address Salisbury, Md. Date signed Nov. 8, 1947
 M. D. or other



801
108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10482
Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

10 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State Md. County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. P.O. # 2
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Stacey Mr. Roland (Roland Linwood Stacey)

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mrs. Maggie Stacey

7. Birth date of deceased (mo., day, yr.)

June 7-18796. (c) If alive, give age 63 years

8. AGE:

Years

Months

Days

If less than one day

68522

hrs.

min.

9. Birthplace

Nanticoke, Maryland
(Town, county, and state)

10. Usual occupation

retired

11. Industry or business

Emp. of a mfg. Plant

FATHER

12. Name

James Stacey

13. Birthplace

Wicomico Co. Maryland

MOTHER

14. Maiden name

Sallie Johnson

15. Birthplace

Wicomico Co. Md.

16. Informant

Mrs. Sallie Stacey

Address

P.O. # 2, Salisbury Md.

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

Dec. 2-47
(month) (day) (year)

Cemetery or crematory

Wicomico Mem. Park

Location

Salisbury Maryland

18. Funeral director

Hollman & Co. R. Hollman

Address

Salisbury Maryland

19. (Date registered by registrar)

12/21/47

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 2919 475:48 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 19 47and that I last saw him alive on Nov. 29 19 47

Immediate cause of death

Myocardial Insufficiency

DURATION

1 yr.Due to AtheroscleroticSymptomsHeart Disease2 yrs.

Due to

Other conditions

—

(Include pregnancy within 3 months of death)

Major findings of operations

—

Date of op.

Autopsy results

—

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

David J. Gilmore M.D.

M. D. or other

Address

304 Camden Ave Salisbury Md.Date signed Nov 29, 1947

RECEIVED
DEC 8 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11 336

1. PLACE OF DEATH:

County Wicomico

City or town Delmar
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Delmar
(If outside city or town limits, write RURAL and give nearest town)

Street No. RFD 3
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

James Stanley

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

WIDOWED

6. (b) Name of husband or wife

Rose Stanley

B. (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.)

Dec. 30, 1856

8. AGE:

Years

Months

Days

If less than one day

90

hrs. min.

9. Birthplace

Birmingham, Alabama

(Town, county, and state)

10. Usual occupation

Operator Concession

11. Industry or business

Games

MOTHER
FATHER

12. Name

Thomas Stanley

13. Birthplace

England

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Eddie Stanley

Address

Delmar, Del.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Nov. 25-47
(month) (day) (year)

Cemetery or crematory

Evergreen

Location

Elizabeth, N.J.

18. Funeral director

Address

U.S. - Grand Co
Delmar, Del.

Nov. 22, 1947
(Date rec'd by registrar)

19

Harry E. Hudson
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21, 1947 at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1947 to Nov 21, 1947

and that I last saw him 11 alive on Nov 21, 1947

Immediate cause of death Chronic Conca

DURATION

2 days

Due to

Chronic Conca

3 yrs

Due to

Chronic Conca

4 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

J. H. Lynch

M. D. or other

Address

Delmar, Del.

Date signed Nov 21, 1947

MARGIN RESERVED FOR BINDING

VS A15 945-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 24 1947

SECRET

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

10484

1. PLACE OF DEATH: Michigan
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
Hospital, institution, or street address where death occurred:
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State.....
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced.....

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... 6.(c) If alive, give age..... years

8. AGE: Years..... Months..... Days..... If less than one day..... hrs..... min.

9. Birthplace..... (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial..... Date thereof.....

(Burial, cremation, or removal. Which?)..... (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. 11/30/47..... (Date rec'd by registrar)..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 19.47. at 3 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... and that I last saw him alive on.....

Immediate cause of death..... DURATION.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Antopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

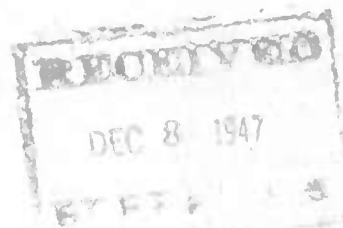
23. SIGNATURE.....

Address..... Date signed.....

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13/a

10485

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Thiomis
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 84 years
 Hospital, institution, or street address where death occurred:
East Main St.
 How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Thiomis
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Lakewood E. Main St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

Charles Irving Hailer

3. (b) Social Security Number

✓

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife ✓
 7. Birth date of deceased (mo., day, yr.) April 26, 1865
 8. AGE: Years 82 Months 6 Days 23 If less than one day hrs. min.

9. Birthplace Salisbury, Thiomis, Md.
 (Town, county, and state)

10. Usual occupation Retired

11. Industry or business Thiomis Separator

12. Name Charles L. Hailer

13. Birthplace Salisbury, Md.

14. Maiden name Anna Todd

15. Birthplace Salisbury, Md.

16. Informant Charles L. Hailer

Address Salisbury, Md.

17. Burial Date thereof 11/21/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Parson

Location Salisbury, Md.

18. Funeral director The Hill & Johnson Co.

Address Salisbury, Md.

19. 11/21 19. 47 Barrie L. Johnson
 (Date read by registrar) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19, 1947 at 3:06 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-10-15 to 11-19-47

and that I last saw him alive on 11-18-47

Immediate cause of death Cardio-vascular renal disease

DURATION

Due to Cardio-vascular renal disease

Due to Cardio-vascular renal disease

Other conditions Cardio-vascular renal disease

(Include pregnancy within 3 months of death)

Major findings of operations Cardio-vascular renal disease

Autopsy results Cardio-vascular renal disease

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Cardio-vascular renal disease Date of 11-27-47

Where did injury occur? Cardio-vascular renal disease (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Cardio-vascular renal disease

Means of injury Cardio-vascular renal disease Injured at work Cardio-vascular renal disease

23. SIGNATURE Philip A. Smith M. D. or other

Address Salisbury, Md. Date signed 11-27-47

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DEC 6 1947

STANDARD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10486

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH

County McComick
City or town Pittsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
R.D. #1.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Md. County McComickCity or town Pittsville
(If outside city or town limits, write RURAL and give nearest town)Street No. R.D. #1.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Thomas Edward Watson

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mrs. J. Annie Watson

7. Birth date of deceased (mo., day, yr.)

Aug. 9-18736. (c) If alive, give age 54 years

8. AGE:

Years

Months

Days

If less than one day

74130

hrs.

min.

9. Birthplace

Marion County Mo.
(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

FATHER

12. Name

John Watson

13. Birthplace

Sum Hill Md.

MOTHER

14. Maiden name

Annie Claywell

15. Birthplace

Sum Hill Md.

16. Informant

Mrs. J. Annie WatsonR.D. #1. Pittsville Md.

17.

Burial

(Burial, cremation, or removal, which?)

Date thereof

Nov. 11-47

(month) (day) (year)

Cemetery or crematory

Harlow Cem.

Location

Near Pittsville Md.

18. General director

Holloway & Co. Walter R. Holloway

Address

Salisbury Maryland

19.

11/14/47

(Date rec'd by registrar)

19.

H. C. EdwardsJohn R. LewisJohn R. Lewis

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 47 at 9 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 1 47 to 11-9-47and that I last saw him alive on 11-9-47

Immediate cause of death

Coronary occlusion

DURATION

2 hours

Due to

Due to

Other conditions

1. Hypertension
2. Atherosclerosis
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Grant R. Lewis Md

M. D. or other

Address

Pittsville MdDate signed 11-10-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10487

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 weeks
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution? 4 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Somerset
 City or town Leicester Avenue, P.D. 1
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Mt Vernon
 (If rural, give LOCATION)
 2. (a) If veteran, name war ✓

3. (a) FULL NAME

Webster, Mr. Fitzhugh Lee

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower
 6. (b) Name of husband or wife Marjorie Webster
 7. Birth date of deceased (mo., day, yr.) June 13, 1867
 6. (c) If alive, give age ✓ years
 8. AGE: Years 80 Months 5 Days 10 If less than one day ✓ hrs. ✓ min.

9. Birthplace Mt Vernon, Somerset, Md.
(Town, county, and state)10. Usual occupation Retired Stationer

11. Industry or business

FATHER 12. Name James W. Webster
 13. Birthplace Somerset Co., Md.
 MOTHER 14. Maiden name Paul Ann Jones
 15. Birthplace Somerset Co., Md.

16. Informant Mr. Clyde M. Carter
 Address Sumner Ave, Md. P.D. 1

17. Burial ✓ Date thereof 11/25/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Green Episcopal
 Location Mt. Vernon, Md.

18. Funeral director Re Nills Johnson Co.
 Address Salisbury, Md.

19. 11/25/47 19 47 Registrar David J. Gilmore
 (Date registered by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23rd 19 47 at 6:24 A.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 27 19 47 to Nov. 23 19 47
 and that I last saw him alive on Nov. 22 19 47

Immediate cause of death Cerebral Thrombosis
 DURATION 5 weeks

Due to Cerebral Arteriosclerosis Unknown
 Due to ✓

Other conditions Artemia due to surgery 7 days
prostatic hypertrophy with obstruction
 (Include pregnancy within 3 months of death)

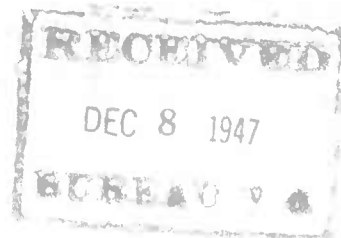
Major findings of operations ✓
 Date of op. ✓

Autopsy results ✓
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide ✓ Date of ✓
 Where did injury occur? ✓ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ✓
 Means of injury ✓ Injured at work? ✓

23. SIGNATURE David J. Gilmore, M.D.
 M.D. or other ✓
 Address 504 Camden Ave Date signed Nov. 23, 1947
Salisbury, Md.



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DEC 8 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

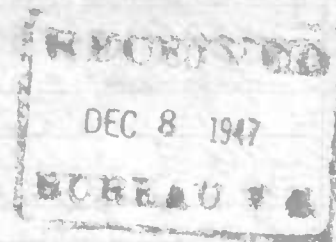
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10488-33

1. PLACE OF DEATH: County <u>Wicomico</u> City or town <u>Salisbury</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>1 mo.</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>MD.</u> County <u>Wicomico</u> City or town <u>Salisbury MD.</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>Lake St.</u> (If rural, give LOCATION) 2.(a) If veteran, name war			
3. (a) FULL NAME <u>Revere Williams</u>				3. (b) Social Security Number			
4. Sex <u>M.</u>	5. Color of skin <u>Cal.</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>		MEDICAL CERTIFICATION			
8. (b) Name of husband or wife <u>none</u>				2D. DATE OF DEATH <u>December 29, 1947</u> at <u>8 A.</u> M.			
7. Birth date of deceased (mo., day, yr.) <u>July 22, 1911</u>				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>November 15th</u> 19 <u>47</u> , to <u>Nov. 29th</u> 19 <u>47</u> , and that I last saw him alive on <u>November 29th</u> 19 <u>47</u> .			
8. AGE: Years <u>36</u> Months <u>4</u> Days <u>7</u> If less than one day _____ hrs. _____ min.				Immediate cause of death <u>Chronic myocarditis</u>			
9. Birthplace <u>Quantico, Wicomico, Md.</u> (Town, county, and state)				DURATION			
10. Usual occupation <u>Farming & Laborer</u>				Due to			
11. Industry or business				Due to			
12. Name <u>Willard Williams</u>				Other conditions <u>Chronic Nephritis</u>			
13. Birthplace <u>Quantico, Md.</u>				(Include pregnancy within 3 months of death)			
14. Maiden name <u>Lizzie Price</u>				Major findings of operations			
15. Birthplace <u>Quantico, Md.</u>				Date of op.			
16. Informant <u>Willard Williams</u>				Autopsy results			
Address <u>Salisbury, Md.</u>				PHYSICIAN: Please underline the cause to which death should be charged statistically.			
17. Burial <u>Burial</u> Date thereof <u>12/3/47</u> (Burial, cremation, or removal. Which?) (month) (day) (year)				22. VIOLENCE: If death was due to external causes, fill in the following:			
Cemetery or crematory <u>Quantico Cemetery</u>				Accident, suicide, or homicide. Date of			
Location <u>Quantico, Md.</u>				Where did injury occur? (City or town) (County) (State)			
18. Funeral director <u>Reverend R. E. Eberhart</u>				Injured at home, farm, industry, public place (where?)			
Address <u>Salisbury, Md.</u>				Means of injury Injured at work?			
19. Date rec'd by registrar <u>10/1/97</u>				23. SIGNATURE <u>William E. Eberhart</u> M. D. or other			
Registrar <u>Reverend R. E. Eberhart</u>				Address <u>Salisbury, Md.</u> Date signed <u>Nov. 29-47</u>			

5-3292



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 933

1. PLACE OF DEATH:

County Wilcomico
 City or town Salisbury Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Wilcomico
 City or town Salisbury Md
 (If outside city or town limits, write RURAL and give nearest town)

Street No. no
 (If rural, give LOCATION)

2.(a) If veteran, name war no

3. (a) FULL NAME

Mary Howell Wright

3. (b) Social Security Number

no4. Sex female 5. Color or race a-a 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife dead 6.(c) If alive, give age no years7. Birth date of deceased (mo., day, yr.) June 11 18708. AGE: Years 77 Months 0 Days 1 If less than one day hrs. min.9. Birthplace Shawell Md
(Town, county, and state)10. Usual occupation Housekeeping11. Industry or business Same as above12. Name Leslie Holland13. Birthplace Shawell Md14. Maiden name Lidde Shawell15. Birthplace Shawell Md16. Informant Madeleine MullerAddress Salisbury Md17. Burial Date thereof Nov. 15, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Green AlesLocation Salisbury Md18. Funeral director Samuel StewartAddress Salisbury Md19. 11/15 1947 Ed. Purcell Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1947 at 5:20 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 5 1947 to Nov. 12 1947and that I last saw her alive on Nov. 12 1947Immediate cause of death Arteriosclerotic heart disease DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. D. Purcell M. D. or otherAddress 800 W. Main St. Salisbury Md Date signed 11/14/47

RECORDED

DEC 5 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. I have correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10491 333

1. PLACE OF DEATH:

County Wilcomio
 City or town Salisbury, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death About four years
 Hospital, institution, or street address where death occurred: no
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wilcomio
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Willie Young

3. (b) Social Security Number

4. Sex male 5. Color or race a.a. 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Clara Wilson Young

7. Birth date of deceased (mo., day, yr.) yes 8. (c) If alive, give age about 1900 years

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Same as above

12. Name Red Young

13. Birthplace South Carolina

14. Maiden name Emma Young

15. Birthplace South Carolina

16. Informant Clara Wilson Young
Address Winston Salem N.C.

17. Burial Date thereof 11-29-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Monterey Cemetery

Location Salisbury Maryland

18. Funeral director James F. Stewart
Address 402 E. Church St. Salisbury Md.

19. 11/29/47 Registrar H. H. Harris

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/29/47 at 5 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____

and that I last saw him medically examined _____ 19____

Immediate cause of death Coronary thrombosis

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations none

Autopsy results none Date of op. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Deputy Medical Examiner M. D. or other _____

Address Salisbury, Md. Date signed 11/29/47

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DEC 6 1947
BUREAU